MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57-2

CERTIFICATE OF DEATH

06908

★ Reg. Diat. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yr. 10 mo. 13 da.

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County: Washington

City or town: Scenery Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. #1
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3. (a) FULL NAME: BRADY, Glenn

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Dora Dean

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): May 8, 1891

8. AGE: Years	Months	Days	If less than one day
54	1	29	— hrs. — min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Civil Engineer

11. Industry or business: -

FATHER
12. Name: Jesse L. Brady
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Ella H. Hildebrand
15. Birthplace: Pennsylvania

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 7-9-45 (month) (day) (year)

Cemetery or crematory: Scenery Hill

Location: Scenery Hill, Pa.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. July 9 1945 (Date rec'd by registrar) Irma E. Dunfee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1945, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24, 1927, to July 7 1945 and that I last saw him alive on July 7 1945

Immediate cause of death	DURATION
Tumor of the mesentery	Undetermined
Arteriosclerosis, general and cerebral	Undetermined
Due to: Thrombosis, cerebral	over 5 years
Pneumonia, terminal	Undetermined
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: —

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: A.E. Trollinger
A.E. TROLLINGER, Lt.Col., M.C., Clinical Director
Address: Veterans Administration, Perry Point, Md.

Date signed: 7-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48a)

CERTIFICATE OF DEATH

06909

Reg. Dist. No. 92

1. PLACE OF DEATH County Elkton - Cecil Co
City or town Union Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred: Union - Elkton
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Cecil
City or town Charlestown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Clara Cather
3.(b) Social Security Number

4. Sex: female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Viodare Cather
6.(c) If alive, give age ___ years
7. Birth date of deceased (mo., day, yr.): July 13, 1899
8. AGE: Years 46 Months Days 10 If less than one day ___ hrs. ___ min.
9. Birthplace: Galena Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —
FATHER 12. Name: John Bishop
13. Birthplace: —
MOTHER 14. Maiden name: Mary Wells —
15. Birthplace: —
16. Informant: Hospital Record
Address: Mary Theo Cather —
17. Burial (Burial, cremation, or removal, Which?) Date thereof July 26, 1945 (month) (day) (year)
Cemetery or crematory: Charlestown
Location: Charlestown, Md.
16. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19 July 23 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945, at 3:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 19 to July 23 1945
and that I last saw her alive on July 23, 1945

Immediate cause of death: Intestinal Obstruction — DURATION 1 week
Due to: Carcinoma of Uterus
Due to: Primary - Carcinoma of Cervix
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: Non operable
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ___ Date of ___
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ___ Injured at work?

23. SIGNATURE H. Scott Cunnell - MD M. D. or other
Address North East Md Date signed July 23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

CERTIFICATE OF DEATH

66910

★

Reg. Diat. No. 92

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

(1)

1. PLACE OF DEATH:
County: Cecil
City or town: Childs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County:
City or town: Glamorgan Va.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Otis Collins

3. (b) Social Security Number: 225-24-1181

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Widower

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 21 1906

8. AGE: Years	Months	Days	If less than one day
38	7	14	hrs. min.

9. Birthplace: Penn (Town, county, and state)
10. Usual occupation: Laborer.
11. Industry or business: Elk Paper Mfg. Co.
FATHER 12. Name: John D Collins
13. Birthplace:
MOTHER 14. Maiden name: Amanda Payne.
15. Birthplace: Elk Paper Manf Co
16. Informant: Childs Md
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof July 17 '45 (month) (day) (year)
Cemetery or crematory:
Location: Norton, Va.
18. Funeral director: H. W. Pierce
Address: Elkton
19. July 16 1945 (Date rec'd by registrar) H R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1945, at 3 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Electrocution	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Electrocution Date of 7-5-45
Where did injury occur? Childs Cecil Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Road.
Means of injury: Live Electric wire Injured at work? No

23. SIGNATURE: R E Dodson M.D. Medical Examiner Cecil County
Address: Elkton Md. M. D. or other
Date signed: 7-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-L)

CERTIFICATE OF DEATH

06911

Reg. Dist. No. 91

1. PLACE OF DEATH:

County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred: Chesapeake City, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Linda Davis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Widowed

6.(b) Name of husband or wife: Capt. Wm Davis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 1, 1867

8. AGE: Years	Months	Days	If less than one day
77	9		..... hrs. ..... min.

9. Birthplace: Bethel, Md (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER — 12. Name: Boyd Jones

13. Birthplace: Chesapeake City, Md

MOTHER — 14. Maiden name: No Information

15. Birthplace

16. Informant: Jos. Davis

Address: Chesapeake City, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 '45 (month) (day) (year)

Cemetery or crematory: Bethel

Location: Near Chesapeake City, Md

18. Funeral director: H. W. Pippin

Address: Elkton, Md

19. July 31st 1945 (Date rec'd by registrar) Mrs. Ralph H. Bell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945 at 3 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1945 to July 28 1945 and that I last saw h.. alive on July 27 1945

	DURATION
Immediate cause of death: Acute Cardiac Dilatation	weeks
Due to: Chronic Myocarditis	6 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Henry Davis M.D. M. D. or other

Address: Chesapeake City Md Date signed 7/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06912

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
Veterans Administration Facility, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County: —

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 717-10th St. N.W., Washington, D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. I

3.(a) FULL NAME: DAVIS, Lyle C.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 13, 1890

8. AGE: Years	Months	Days	If less than one day
55	1	15	— hrs. — min.

9. Birthplace: Dodge City, Kansas
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: —

FATHER
12. Name: Unknown
13. Birthplace: —

MOTHER
14. Maiden name: —
15. Birthplace: —

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7-30-45 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: Pennington & Son, Havre de Grace, Md.

19. July 30 1945 (Date rec'd by registrar) Irma E. Dingle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1945, at 4:25A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1945, to July 28 1945

and that I last saw h... im alive on July 28 1945

Immediate cause of death — DURATION

Tuberculosis, pulmonary, chronic far advanced, active — Unknown

Due to:

Due to:

Other conditions: Disease of the Aorta, Aneurysm, diffuse — Unknown
(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: A.E. Trollinger

A.E. TROLLINGER Lt.Col., M.C., Clinical Director, M.D. or other

Address: Veterans Administration, Perry Point, Md.

Date signed: 7/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Cecil

Veterans Administration,Perry Point,Md.

3 days

Veterans Administration Facility,Perry Point,
Md.

Same as above

DAVIS, Lyle C.

Male	White	Single		

June 13, 1890

35	1	15	-	-	-

Dodge City, Kansas

Mechanic

Unknown
"
"
"

Hospital Records

Veterans Administration,Perry Point,Md.

Removal 7-30-45

Arlington National Cemetery
Arlington, Va.

Pennington & Son, Havre de Grace,
Md.

98

D.C.

Washington

212-10th St. N.W., Washington,D.C.

N.W. 1

July 25 46 45 July 28 45

Tuberculosis, pulmonary, chronic
far advanced, active Unknown

July 28 45

July 26 45 4:30A.

Disease of the Aorta,
Aneurysm, diffuse Unknown

Not performed

Veterans Administration,
Perry Point, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176)

06913

CERTIFICATE OF DEATH ★

Reg. Dist. No. 96

1. PLACE OF DEATH: CECIL COUNTY
County Veterans Administration, Perry Point, Md.
City or town Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Veterans Administration Perry Point, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Penna. County Montgomery
City or town Hatboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. Governor's Rd. & Davis Grove Road
(If rural, give LOCATION)
2.(a) If veteran, name war WW I

3. (a) FULL NAME: DECKER, Allen B.

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Davis Decker
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): January 4, 1894

8. AGE: Years	Months	Days	If less than one day
51	6	6	- hrs. - min.

9. Birthplace: Bala Cynwyd, Pa. (Town, county, and state)
10. Usual occupation: Architect
11. Industry or business: -

FATHER
12. Name: William H. Decker
13. Birthplace: Louisville, Ky.

MOTHER
14. Maiden name: Caroline Dell
15. Birthplace: Philadelphia, Pa.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7-10-45 (month) (day) (year)
Cemetery or crematory: Westminister Cemetery
Location: Montgomery County, Pa.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. July 10 19 45 (Date rec'd by registrar) Registrar: Irma E. Laughlon

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 19 45, at 8:28 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 19 45, to July 10 19 45 and that I last saw him alive on July 10 19 45

Immediate cause of death	DURATION
Parkinson's Syndrome	Over 5 years
Due to:	
Due to:	
Other conditions: Ulcer, Duodenal	Undetermined

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op.: -
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, Lt. Col., M.C. Clinical Director
Veterans Administration
Perry Point, Md.
Date signed 7-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

06914

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:

County: Cecil

City or town: Rising Sun - (Near Greenbush)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: (Near) Greenbush md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Cecil Elsworth Dennison

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1866

8. AGE:	Years	Months	Days	If less than one day
	79	4	29	...hrs. ...min.

9. Birthplace: Porters Bridge, Clare, md.
(Town, county and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER
12. Name: Joseph T. Dennison
13. Birthplace: New Garden, Pa.

MOTHER
14. Maiden name: Nancy J. Nelson
15. Birthplace: York Co. Pa.

16. Informant: Nettie Dennison

Address: Rising Sun md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 27, 1945 (month) (day) (year)

Cemetery or crematory: Union

Location: Freemont, Pa.

18. Funeral director: Ralph M Reed

Address: Rising Sun, md.

19. July 25 1945 H. L. Worthington Registrar
(Date rec'd by registrar)

Certificate received 9-24-45

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 - 1945 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1940 to July 23 - 1945 and that I last saw him alive on July 23 - 1945

Immediate cause of death	DURATION
Chronic Myocarditis	1 yrs
Due to	
Due to	
Other conditions Chronic Endocarditis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. J. Benson, M. D.
M. D. or other

Address: Port Deposit Md Date signed 7-25-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

06915

CERTIFICATE OF DEATH ★

Reg. Dist. No. 97

1. PLACE OF DEATH

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours.

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 2 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pa. County: Chester

City or town: Lenoville Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Judah Dixon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife: Reuben L. Dixon

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): June 22. 1887.

8. AGE: Years: 58 | Months: | Days: 17. | If less than one day: ..... hrs. ..... min.

9. Birthplace: Jefferson. N.C. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER — 12. Name: Preston C. Dixon

13. Birthplace: Jefferson. N.C.

MOTHER — 14. Maiden name: Lola Goodman.

15. Birthplace: Jefferson. N.C.

16. Informant: Reuben L. Dixon

Address: Lenoville Pa.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: July 10/45 (month) (day) (year)

Cemetery or crematory: West Jefferson

Location: West Jefferson N.C.

18. Funeral director: H.B. Pippen

Address: Elkton, Md.

19. July 10 1945 (Date rec'd by registrar) F.R. Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July. 9 1945, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Crushed chest	
Right side.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident. Date of: 7-9-45

Where did injury occur? Lenoville. Cecil Co. Pa.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home.

Means of injury: Automobile Injured at work?

Medical Examiner Cecil County

23. SIGNATURE: R.L. Dodson M.D.

M. D. or other

Address: Rising Sun Md. Date signed: 7-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on

FILM No G 97 AUG 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

06916

Reg. Dist. No. 91

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Cecil
City or town Hacks Pt Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred: Chesapeake City R.D.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Cecil
City or town Rural near Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No. Chesapeake City, Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bertha V. Douglass

3.(b) Social Security Number 214-20-4893

4. Sex F
5. Color or race Wh
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Walter K Douglass
6.(c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) September 12, 1894

8. AGE: Years 51 50 Months 10 Days 20 If less than one day ....hrs. ....min.

9. Birthplace Philadelphia, Pa
(Town, county, and state)
10. Usual occupation House wife
11. Industry or business

FATHER
12. Name David A. Pitts
13. Birthplace Ireland

MOTHER
14. Maiden name Sarah A Gunn
15. Birthplace Pa

16. Informant Walter K Douglass
Address Earleville, Md

17. Burial & trans Date thereof July 6, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fernwood
Location 1811 S 55 St Phila, Pa

18. Funeral director H W Pippin
Address Elkton, Md

19. July 3rd 1945 Mrs Ralph H. Rees
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 11 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1945, to July 1 1945
and that I last saw her alive on Jun 30 1945

	DURATION
Immediate cause of death Hemiplegia right side	3/25/45
Due to Rupture of cerebral vessel	3/25/45
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur?
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Henry Davis MD
M. D. or other
Address Chesapeake City Md Date signed 7/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06917

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 63 years.

Hospital, Institution, or street address where death occurred: Elkton Hts.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil.

City or town: Elkton Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Elkton Hts.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry C. Evans.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh	Married.

6.(b) Name of husband or wife: Viola M. Evans.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 12, 1882

8. AGE: Years	Months	Days	If less than one day
63.	2	29	..... hrs. ..... min.

9. Birthplace: Elkton, Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Wm S. Evans

FATHER — 13. Birthplace: Rising Sun, Md.

MOTHER — 14. Maiden name: Jennie Frazer

MOTHER — 15. Birthplace: New Elkton, Md

16. Informant: Mr Stanley Evans.

Address: Elkton, Md

17. Burial. (Burial, cremation, or removal. Which?) Date thereof July 13 1945 (month) (day) (year)

Cemetery or crematory: Elkton

Location: Elkton, Md

18. Funeral director: H. W. Pippin

Address: Elkton, Md

19. July 13 1945 (Date rec'd by registrar) F R Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1945, at 4 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 30 to July 11 19 45

and that I last saw him alive on July 10 19 45

Immediate cause of death	DURATION
Coronary thrombosis	10 min.
Due to	
Due to	
Other conditions: Arthritis deformans	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Herbert Bates, M. D. M. D. or other

Address: Elkton Md. Date signed 7/12/45

M

I

T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-4)

CERTIFICATE OF DEATH

06918

Reg. Diat. No. 94

1. PLACE OF DEATH:

County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Ellen F. Ford

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Edwin Ford

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 26 1864

8. AGE: Years: 81 Months: 1 Days: — If less than one day: ... hrs. ... min.

9. Birthplace: North East Cecil Co. Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER — 12. Name: Hiram W Shallcross

13. Birthplace: Penna

MOTHER — 14. Maiden name: Mary E Gracke

15. Birthplace: Del

16. Informant: Alvin Ford

Address: North East Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 29-45 (month) (day) (year)

Cemetery or crematory: Methodist

Location: North East Md

18. Funeral director: Joseph R Green

Address: North East Md

19. July 28 19 45 (Date rec'd by registrar) Lida F Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1945, at 7.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to July 26 1945

and that I last saw h... alive on July 25 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	—
Due to: Chronic Nephritis	1
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed: July 27 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

FILM No. G 97 JUL 31 1945

CERTIFICATE OF DEATH

06919

★ Reg. Dist. No. 95

1. PLACE OF DEATH:

County: Cecil

City or town: near Colora Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Colora Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John C. Frist

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Olive Frist

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Aug. 17. 1872.

8. AGE: Years	Months	Days	If less than one day
72 ~~73~~	11	5	hrs. min.

9. Birthplace: Port Deposit Cecil Co Md.

(Town, county, and state)

10. Usual occupation: Farmer + Guard

11. Industry or business

FATHER — 12. Name: Edmund Frist

13. Birthplace: Port Deposit. Md.

MOTHER — 14. Maiden name: Mary Jane Haines

15. Birthplace: Port Deposit Md.

16. Informant: Mrs. John C. Frist

Address: Colora. Md. R. F. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25 1945 (month) (day) (year)

Cemetery or crematory: Hopewell

Location: near Port Deposit Md.

18. Funeral director: J. E. Tyson.

Address: Principio Furn. Md.

19. 7/23 19 45 Lm Worthington Registrar

(Date rec'd by registrar)

Permit 7-23-45

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 - 45 at 5 40/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1945 to July 22 1945 and that I last saw him alive on July 22 1945.

Immediate cause of death	DURATION
Coronary Occlusion	2 days
Due to	
Due to	
Other conditions: Abrasive Myocarditis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. H. Broom M.D. M. D. or other

Address: Port Deposit Md. Date signed 7-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 192

CERTIFICATE OF DEATH

06920

Reg. Dist. No. 94

1. PLACE OF DEATH:

County: Cecil

City or town: Charlestown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pa. County: Berks

City or town: Reading

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Lancaster Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: not a Veteran

3. (a) FULL NAME John Gabriel

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 11 1928

8. AGE:

Years	Months	Days	If less than one day
16	11	21	..... hrs. ..... min.

9. Birthplace: Reading Berks Co. Penna (Town, county, and state)

10. Usual occupation: Knitter

11. Industry or business: Hosiery Mill

FATHER

12. Name: John Gabriel

13. Birthplace: Penna

MOTHER

14. Maiden name: Clara Eck

15. Birthplace: Reading Penna

16. Informant: Mrs Clara Gabriel

Address: Lancaster Ave Reading Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5 1945 (month) (day) (year)

Cemetery or crematory: Laurel dale

Location: Reading Penna

18. Funeral director: Joseph R. Stamp

Address: North East Md

19. 7-2-1945 (Date rec'd by registrar) Lois D. Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1945, at 4.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Struck by Lightening	
Due to Electric Storm	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-2-45

Where did injury occur? Holloway Road Cecil Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Beach.

Means of injury Lightning Injured at work? .....

23. SIGNATURE: R. LeDodson M.D. Medical Examiner Cecil County

Address: Rising Sun Md M. D. or other

Date signed 7/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

06921

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mo. 7 da.

Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. 2

3.(a) FULL NAME: GARLITZ, John L.

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): October 19, 1922

8. AGE: Years	Months	Days	If less than one day
22	8	19	- hrs. - min.

9. Birthplace: Mt. Savage, Md.
(Town, county, and state)

10. Usual occupation: Factory Worker

11. Industry or business: -

FATHER
12. Name: Jesse C. Garlitz
13. Birthplace: Elk Lick, Pa.

MOTHER
14. Maiden name: Estella C. Baer
15. Birthplace: Sand Patch, Pa.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 9, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Savage

Location: Mt. Savage, Md.

18. Funeral director: Penny & Rea
PENNINGTON & SON, Havre de Grace, Md.
Address

19. July 9 19 45 Irene E. Dunphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 19 45 at 5:00P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1 19 44 to July 8 19 45 and that I last saw him alive on July 8 19 45

Immediate cause of death	DURATION
Accidental Drowning	Immediate
Due to	
Due to	
Other conditions: Dementia Precox, Hebephrenic Type	Over 15 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 7-8-45

Where did injury occur? Veterans Administration, Perry Point, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Veterans Hospital, Perry Point, Md.

Injured at work? -

Means of injury: -

23. SIGNATURE: R. E. Dockson M.D. Medical Examiner

Address: Rising Sun Md. M. D. or other Cecil County

Date signed: 7-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06922

★ Reg. Diat. No. 90

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (M) MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County... Cecil

City or town... Warwick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 5 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Cecil

City or town... Warwick

(If outside city or town limits, write RURAL and give nearest town)

Street No...

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME Bayard S. Jordan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife... Helen Eaton Jordan

6.(c) If alive, give age... 61 years

7. Birth date of deceased (mo., day, yr.) April 11th, 1877

8. AGE: Years 68 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Del (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Howard Jordan

13. Birthplace Del

MOTHER 14. Maiden name Alice Lyman

15. Birthplace Del

16. Informant Mrs Bayard S. Jordan

Address Warwick Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/29/45 (month) (day) (year)

Cemetery or crematory Bethel Cemetery Chesapeake

Location ...

18. Funeral director G. Luther Daniels

Address Townsend Del.

19. 7-28-1945 (Date rec'd by registrar) Thomas Burke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/26/1945 at 12.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1/45 19... to 7/25/45 19...

and that I last saw h... alive on 7/25/45 19...

Immediate cause of death	DURATION
1. Chronic Bronchitis	2 years
Due to 2. Rheumatic heart disease	32 years
Due to 3. Acute Cardiac decompensation	1 week
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury Injured at work?

23. SIGNATURE Walter R. Lewis M. D. (M. D. or other)

Address Middletown Date signed 7/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1647)

06923

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Elkton Heights
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William Ray Kerr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married.

6.(b) Name of husband or wife: Mildred Kerr.
6.(c) If alive, give age: 45 years
7. Birth date of deceased (mo., day, yr.): Aug 10 1888.

8. AGE: Years	Months	Days	If less than one day
56	11	18	hrs. min.

9. Birthplace: Lemasville Pa. (Town, county, and state)
10. Usual occupation: Butcher
11. Industry or business
FATHER 12. Name: William Kerr.
FATHER 13. Birthplace: Lemasville Pa.
MOTHER 14. Maiden name: Malessia McCleary.
MOTHER 15. Birthplace: Fairhill Md.
16. Informant: Mrs Jayne Lungren
Address: Elkton R#5 Md.
17. Burial (Burial, cremation, or Removal. Which?) Date thereof July 30 45 (month) (day) (year)
Cemetery or crematory: Shoppa New Fairhill, Md
Location: near Fairhill Md
18. Funeral director: N. W. Popkin
Address: Elkton, Md
19. July 30 1945 (Date rec'd by registrar) F R Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1945; at 3 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Gun shot	
Due to: wound of	
chest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Suicide Date of 7-28-45
Where did injury occur? Elkton Rd Cecil Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Shot Gun. Injured at work?

23. SIGNATURE: R. L. Woodcock M.D. Medical Examiner for Cecil County
M. D. or other
Address: Rising Sun Md Date signed: 7-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06924

Reg. Dist. No. 96

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yr. 9 mo. 4 da.

Hospital, Institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County: -

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 304 F Street, N.W. Apt. 304
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3. (a) FULL NAME: KUNKEL, James D.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Christine ? Kunkel

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): August 31, 1893

8. AGE: Years	Months	Days	If less than one day
51	10	7	- hrs. - min.

9. Birthplace: Harrisburg, Pa.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: -

FATHER — 12. Name: Unknown

13. Birthplace: W

MOTHER — 14. Maiden name: W

15. Birthplace: W

16. Informant: Hospital Records, Veterans Administration

Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7-10-1945 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Fuoeral director: Penny & Son

Address: Havre de Grace, Md.

19. July 10 1945 (Date rec'd by registrar) Irma E. Dugle (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1945 at 8:55 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 4 1940 to July 8 1945

and that I last saw him alive on July 8 1945

Immediate cause of death	DURATION
Other diseases of the circulatory system	Undetermined
Thrombosis, mesenteric	Undetermined
Due to	
Other conditions: Psychosis with cerebral syphilis	
Meningo-vascular	5 yr. 6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A. E. Trollinger

Address: A. E. TROLLINGER, LT. COL. M.C. M.D. or other
CLINICAL DIRECTOR VETERANS ADMINISTRATION PERRY POINT, MD. Date signed 7-9-45

Greenwald

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

06925

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo.

Hospital, Institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 5 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 139 Collard Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Lee

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Widowed

6.(b) Name of husband or wife: Joseph Lee

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
82				

9. Birthplace: (Town, county, and state)

10. Usual occupation: No

11. Industry or business:

FATHER — 12. Name: Johnston

13. Birthplace:

MOTHER — 14. Maiden name:

15. Birthplace:

16. Informant:

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20/45 (month) (day) (year)

Cemetery or crematory: The Manor.

Location: Near Chesapeake City, Md.

19. Funeral director: H. W. Lippincott

Address: Elkton, Md.

19. July 20 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1945 at 6:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945 to July 17 1945 and that I last saw h[illegible] alive on July 17 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hrs
Due to Chronic Nephritis	2
Due to Senility	yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jas. J. Greenwald M. D. or other

Address: Elkton, Md. Date signed JUL 20 1945

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-4)

CERTIFICATE OF DEATH

06926

★ Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton RD 3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 1 wk

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton Md RD 3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Anna Lishwid

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Michael Lishwid
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 18 1888

8. AGE: Years	Months	Days	If less than one day
56	7	25	..... hrs. ..... min.

9. Birthplace: Austria (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Theodore Wolas
13. Birthplace: Austria

MOTHER
14. Maiden name: Unknown
15. Birthplace: Austria

16. Informant: Nicholas Lishwid
Address: Elkton Md RD 3

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 1945 (month) (day) (year)
Cemetery or crematory: St Marys. Fox Chase
Location: Philadelphia Pa
18. Funeral director: H A Phipps
Address: Elkton Md

19. July 16 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1945 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to July 13 1945 and that I last saw her alive on July 12 1945

Immediate cause of death	DURATION
(a) Chronic myocarditis	3 yrs.
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Jas J Kenworthy M.D. M. D. or other
Address: Elkton Md Date signed: July 14/45

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06927

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mo 6 days
Hospital, Institution, or street address where death occurred: 107 Hollingsworth Manor
How long in hospital or institution? Elkton Md

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 107 Hollingsworth Manor
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Ernest Martin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife: —

7. Birth date of deceased (mo., day, yr.): July 3 1945

8.(c) If alive, give age: ..... years

8. AGE:

Years	Months	Days	If less than one day
0	5	6	..... hrs. ..... min.

9. Birthplace: Elkton Cecil Md
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Charles Martin
13. Birthplace: Hagerstown Md

MOTHER
14. Maiden name: Virginia Justus
15. Birthplace: Grafton, W Va

16. Informant: Mrs. Virginia Martin
Address: 107 Hollingsworth Manor Elkton

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7 1945 (month) (day) (year)
Cemetery or crematory: Elkton cemetery
Location: Elkton Md

18. Funeral director: H. A. Tippin
Address: Elkton Md

19. July 7 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1945, at 4 30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1 1945 to July 3 1945 and that I last saw him alive on July 2 1945

Immediate cause of death	DURATION
Severe Nutritional Deficiency	6 - 1
Due to	
Due to	
Other conditions: Malnutrition	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Milford W. Spreche, MD
M. D. or other
Address: Elkton, Md Date signed July 5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

06928

CERTIFICATE OF DEATH

★ Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Earl Miller

3.(b) Social Security Number 213-18-3118

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Catherine Rachel Miller deceased
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 1, 1910

8. AGE: Years	Months	Days	If less than one day
35	4	14	hrs. min.

9. Birthplace: Erwin, Unicoi Co., Tennessee (Town, county, and state)
10. Usual occupation: Asst. Track Foreman
11. Industry or business: Penna. R.R.
FATHER 12. Name: James Miller
FATHER 13. Birthplace: Erwin, Tennessee
MOTHER 14. Maiden name: Loretta Miller
MOTHER 15. Birthplace: North Carolina
16. Informant: James Miller
Address: Port Deposit, Md. Rural
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18, 1945 (month) (day) (year)
Cemetery or crematory: Idlewell
Location: Port Deposit Md. Rural
16. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. July 18 1945 Irene E. Daugherty (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1945, at 6 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1944 to July 15 1945
and that I last saw h... alive on July 15 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: E. J. Brown M.D.
M. D. or other
Address: Port Deposit Md. Date signed 7-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B7-2)

06929

CERTIFICATE OF DEATH ★

Reg. Dist. No. 96

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md. (Veterans Administration)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo. 15 days

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 43 - 16th St., N.E.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3. (a) FULL NAME: MILLER, John T.

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Unknown (Deceased)

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 49 yrs. 5 mo. 7 da. 1-26-1896

8. AGE: Years	Months	Days	If less than one day
49	5	7	- hrs. - min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -

FATHER
12. Name: John Miller
13. Birthplace: Dist. of Columbia

MOTHER
14. Maiden name: Katie Lee
15. Birthplace: Dist. of Columbia

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 5, 1945 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Fort Myer, Virginia.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Maryland.

19. July 5, 1945 (Date rec'd by registrar) Irma E. Murphy, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3, 1945, at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18, 1944 to July 3, 1945 and that I last saw him alive on July 3, 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	10 days
Due to: Multiple Sclerosis	4 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A. E. Trollinger M.D. or Other

Address: A. E. TROLLINGER, Lt. Col., M.C. Clinical Director, Veterans Administration, Perry Point, Md. Date signed: 7-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

06930

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0
Hospital, institution, or street address where death occurred: Elkton R.D. Route 40
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: N.C. County: Forsyth
City or town: Winston Salem.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: James Monroe Myers.

3.(b) Social Security Number: 239-38-5150

4. Sex: M.
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife: Bertha Myers
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): March 18, 1888

8. AGE: Years: 57 Months: 4 Days: 0 If less than one day: ....hrs. ....min.

9. Birthplace: Wilk Co N.C.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: John Myers
FATHER 13. Birthplace: Allegheny Co N.C.
MOTHER 14. Maiden name: Amanda Felts
MOTHER 15. Birthplace: North C.
16. Informant: Ray Charles
Address: 715 N. Adams St. Hayes de Grad
17. Burial, cremation, or removal. Which?: Removal
Date thereof: July 20/45 (month) (day) (year)
Cemetery or crematory: Winston Salem N.C.
Location: Winston Salem, N.C.
18. Funeral director: H.W. Lapsley
Address: Elkton, Md
19. (Date rec'd by registrar): July 19 1945
Registrar: F.R. Seay

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1945, at 9a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....
and that I last saw h....alive on ....19....

Immediate cause of death: Crushed Chest & pelvis. — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 7-18-45
Where did injury occur? Elkton Rural Cecil Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Rte 40
Means of injury: Automobile Injured at work?

23. SIGNATURE: R.L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address: Rising Sun Md. Date signed: 7-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

06931

Reg. Dist. No. 92

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Ernest Painter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife

6.(c) If olive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 15 1943

8. AGE:

Years	Months	Days	If less than one day
3	3	16	..... hrs. ..... min.

9. Birthplace: Elkton Md.

(Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER

12. Name: Harry Painter

13. Birthplace: Rocks Bun. Co.

MOTHER

14. Maiden name: Rena Green

15. Birthplace: Franklin Co Va.

16. Informant: Mrs H Painter

Address: Elkton R.D. 1 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4 1945 (month) (day) (year)

Cemetery or crematory: Ebenezer

Location: Near Pilgrims Lutheran Md.

18. Funeral director: J. E. Tyson

Address: Rising Sun Md.

19. July 2 1945 (Date rec'd by registrar) H R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1945 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... to ..... and that I last saw h... alive on .....

	DURATION
Immediate cause of death: Drowned.	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 7-1-45

Where did injury occur? Elkton (City or town) R.D. Cecil (County) 2nd (State)

Injured at home, farm, industry, public place (where?) Plum Creek

Means of injury: Drowned. Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County

M. D. or other

Address: Rising Sun Md. Date signed 7-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06932

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Rural New North East Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, Institution, or street address where death occurred: North East R.D

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Rural New North East Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. North East R.D

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Henry Reynolds

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	Widowed

6.(b) Name of husband or wife: Florence Reynolds

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 19, 1872

8. AGE: Years	Months	Days	If less than one day
72	9	11	hrs. min.

9. Birthplace: North East R.D (Town, county, and state)

10. Usual occupation: Retd.

11. Industry or business

FATHER

12. Name: Richard Reynolds

13. Birthplace: North East R.D.

MOTHER

14. Maiden name: Martha Jane Donahue

15. Birthplace: Maryland

16. Informant: Thomas Reynolds

Address: North East R.D. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5 1945 (month) (day) (year)

Cemetery or crematory: North East Methodist

Location: North East, Md

18. Funeral director: H. W. Lippincott

Address: Elkton, Md.

19. 7/5/ 1945 (Date rec'd by registrar) Lydia E. Owens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1945 to July 2 1945 and that I last saw him alive on July 2 1945

Immediate cause of death: Mitral Stenosis — DURATION: 16 mo.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: C B Collins M. D. or other

Address: North East Md Date signed: 7-5-45

06933

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH (WG)

County Cecil Registration Dist. No. 700

Village or City Sassafras No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME John Robinson If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Colored	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie Robinson

6. DATE OF BIRTH (month, day, and year) March 25-1884

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Laborer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Farming

10. Date deceased last worked at this occupation (month and year) May 1945

11. Total time (years) spent in this occupation 45 yrs

12. BIRTHPLACE (city or town) Virginia
(State or country)

FATHER

13. NAME unknown

14. BIRTHPLACE (city or town) unknown
(State or country)

MOTHER

15. MAIDEN NAME unknown

16. BIRTHPLACE (city or town) unknown
(State or country)

17. INFORMANT Annie Robinson
(Address) Sassafras Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Sassafras Md. Date July 31, 1945

19. UNDERTAKER Austin A Couch
(Address) Middletown Del

20. FILED 7/21, 1945 Wm Orme Dyer
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 27th (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 1, 1945 to July 27, 1945

I last saw him alive on July 27, 1945; death is said to have occurred on the date stated above, at 9:55 P. M.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

Cancer of Stomach — Date of onset 6 mo,

Other **Contributory Causes** of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Natura of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) J. B. Gilpin M. D.

(Address) Middletown Del

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

06934

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: VETERANS ADMINISTRATION, PERRY POINT, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mo. 15 da.
Hospital, Institution, or street address where death occurred:
VETERANS ADMINISTRATION FACILITY, PERRY POINT
How long in hospital or institution? 5 months, 15 days MD.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist. Columbia County: -
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 803 - 25th Street, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3. (a) FULL NAME: SCOTT, Walter

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): F January 1, 1893

8. AGE: Years	Months	Days	If less than one day
52	6	16	- hrs. - min.

9. Birthplace: Unknown
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: -

FATHER
12. Name: John Joseph Scott
13. Birthplace: Charleston, S.C.

MOTHER
14. Maiden name: Sarah Scott
15. Birthplace: Charleston, S.C.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 20, 1945 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.
18. Funeral director: Pennington & Son
Address: Pennington & Son, Havre de Grace, Md.

19. July 20 19 45 (Date rec'd by registrar) Irma E. Dempsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 19 45 8:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3, 19 45, to July 18 19 45
and that I last saw him alive on July 18 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 month
Due to: Arteriosclerosis, cerebral	Unknown
Due to: Psychosis with Cerebral Arteriosclerosis	Unknown
Other conditions: -	

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op.: -
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work? -

23. SIGNATURE: A. F. Trollinger
A. F. TROLLINGER, Lt. Col., M.C., Clinical Director
Veterans Administration
Address: Perry Point, Md.
Date signed: 7-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ 06935

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Bainbridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? five (5) hours

Hospital, institution, or street address where death occurred: US Naval Hospital, NavTraCen Bainbridge, Md.

How long in hospital or institution? Five (5) Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Bainbridge Village

(If outside city or town limits, write RURAL and give nearest town)

Street No. 921, Apt 14

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: James Harry SOLFISBURG

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	-

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7/5/45

8. AGE: Years	Months	Days	If less than one day
-	-	-	five hrs. min.

9. Birthplace: USNH NavTraCen Bainbridge, Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Harry James SOLFISBURG

FATHER — 13. Birthplace: Marysville, Calif.

MOTHER — 14. Maiden name: Harriett Lillian FEELEY

MOTHER — 15. Birthplace: Oakland, Calif.

16. Interment: USNH NavTraCen

Address: Bainbridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6, 1945 (month) (day) (year)

Cemetery or crematory: West Nottingham

Location: Colora, Md. Rural

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. July 7 - 45 (Date rec'd by registrar) Irene E. Daughty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 July 19 45, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 July 1945 to 5 July 1945 and that I last saw him alive on 5 July 1945

Immediate cause of death	DURATION
Prematurity	
Atelectasis	
Due to: Placental anomaly	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Atelectasis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Harold M. Cohen MD. M. D. or other

Address: Naval Hospital, Bainbridge, Md. Date signed: 7/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 6936 94

1. PLACE OF DEATH:

County: Cecil

City or town: North East, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn tufants give residence of mother)

State: Maryland County: Cecil

City or town: North East Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: Not a veteran

3. (a) FULL NAME: James J W White

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 1 - 1885

8. AGE: Years	Months	Days	If less than one day
60	2	26	..... hrs. ..... min.

9. Birthplace: Belfast Ireland
(Town, county, and state)

10. Usual occupation: Watchman

11. Industry or business: B. & O. Railroad

FATHER — 12. Name: John J White

FATHER — 13. Birthplace: Belfast, Ireland

MOTHER — 14. Maiden name: Jane Romney

MOTHER — 15. Birthplace: Belfast, Ireland

16. Informant: John White

Address: Wilmington, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30 1945 (month) (day) (year)

Cemetery or crematory: Methodist cemetery

Location: Cherry Hill Md

18. Funeral director: Joseph R. Grant

Address: North East, Md.

19. July 28 1945 (Date rec'd by registrar) Grace D. Emma Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1945 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 1945 to July 27 1945 and that I last saw h.. alive on July 27 1945

Immediate cause of death	DURATION
Angina Pectoris	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C B Collins M. D. or other

Address: North East, Md Date signed: 7-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

06937

Reg. Dist. No. 94

1. PLACE OF DEATH:
County: Cecil
City or town: North East Rural.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? several years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: North East.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: not a veteran

3.(a) FULL NAME Robert H. White

3.(b) Social Security Number 215-16-7431

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 24 1874

8. AGE: Years 70 | Months 10 | Days 5 | If less than one day: hrs. min.

9. Birthplace: North East Rural (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Samuel R. White
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary E. Lotman
15. Birthplace: Maryland

16. Informant: Mrs Edna White
Address: Ardsley New York

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 1 1945 (month) (day) (year)
Cemetery or crematory: methodist
Location: North East, Md

18. Funeral director: Joseph R Evans
Address: North East Md

19. Aug 1st 1945 (Date rec'd by registrar) Lida V. Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 1945, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address: Rising Sun Md Date signed 7/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING